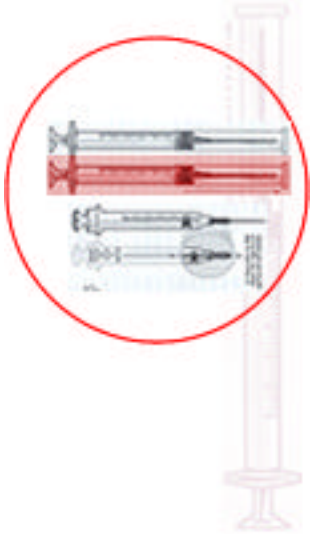
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



Phase 1 Report
Formation of the Sharps Injury Prevention Team

This nursing care center is a 500-bed JCAHO accredited long-term care facility that provides 24-hour care to psycho-behavioral and medically/physically handicapped residents with intermediate and skilled nursing care needs. Provision of care is accomplished by 600 employees in the following departments: Medical, Nursing (including Infection Control), Quality Improvement, Respiratory Therapy, Activity Therapy, Occupational Therapy, Pharmacy, Chaplaincy, Physical Therapy, Nutritional, Environmental, Education, Speech & Hearing, Social Work, Health Information, Supply, Volunteer, Physical Plant and Employee Health.

In 2001, Infection Control Practitioners evaluated all sharp medical devices used in the facility and implemented necessary changes in products or practices to comply with OSHA's Blood-borne Pathogens Standard. We wanted to participate in the NIOSH project to determine if this formal process of selecting and evaluating safer medical devices as outlined in the NIOSH *ALERT: Preventing Needlestick Injuries in Healthcare Settings* yields a different result than we obtained in 2001.

TEAM FORMATION

As the Infection Control Practitioners for the facility, we focused on two significant criteria: who were the "users" of sharps devices and who would be influential in product promotion (purchasing, education etc). We also wanted to include a member on the team who had experienced an exposure injury. We contacted each potential member by phone, provided a brief overview of team goals and asked for their participation. We allowed them to decline or delegate membership and all willingly accepted membership on the team. While attending another administrative committee, we announced the formation of this team. From this meeting, an additional member was added from our facility's quality improvement team. A welcome note and notification of the first meeting was sent out by e-mail or was hand-delivered.

BEGINNINGS

During the first Sharps Injury Prevention Team meeting, members pared the participant list by three and converted them to ad hoc member status. Our preference was to keep one individual from management committee on the team to solicit support. Our final membership roster is located in Table 1.

Table 1

Job Title	Department	Management	Device User
LPN	Nursing		X
LPN	Nursing		X
Head Nurse	Nursing		X
QI Coordinator	Administration	X	
Risk Manager	Administration	X	
Beauty & Barber Supervisor	QI	X	X
Nurse Practitioner	Medical		X
Employee Health Nurse	Nursing		X
Supply Manager*	Administration	X	
Pharmacy Director*	Medical	X	
Physical Therapy Director	Medical	X	X
Education Director	Administration	X	
Administrator* **	Administration	X	
Infection Control Coordinator	Nursing	X	
Infection Control Practitioner	Nursing	X	

*Ad hoc **Management Committee Member

The team members decided the Infection Control Practitioners would alternate as team coordinators. Both Infection Control Practitioners are credentialed with a BSN; the Infection Control Coordinator has a Masters Degree in Education. Infection Control Practitioners function in interchangeable roles in meetings - leading, guiding, facilitating, recording and/or providing information. Team decisions were made regarding format, meeting times, places, and the need for more information about the process.

LESSONS LEARNED

A knowledge deficit was noted in the first meeting especially in departments that use sharps infrequently. The team requested clarification of definitions for a sharp and sharps injuries. They were also interested in the most common sharps injuries at the facility. Perhaps it would be more helpful if the definitions and sharps information were provided at the first

meeting. One way to communicate information is with the NIOSH ALERT booklet. We would recommend ordering booklets prior to the formation of the team to facilitate distribution at the first meeting.

We would recommend having an employee with a previous exposure discuss their experience early in the process to increase interest and commitment for selecting and evaluating safer medical devices.

STAFF HOURS AND OTHER COST ISSUES

Cost issues are broken down into two areas: materials and staff hours. Materials used for this step included computer, paper, OSHA Guidelines and NIOSH Alert booklets (one for each member). We found that the coordinators devoted multiple hours to secretarial duties. We would recommend obtaining secretarial support at the beginning the process if possible. Staff hours in the formation of the team are reflected in the following chart:

Type of Staff	Hours Spent on Phase I
Team Coordinators	13
Management	8
Administrative	5
Device Users	11
Total	37